

# Patient Health History

Today's Date  /  Signature of Patient \_\_\_\_\_

Patient Title: (check one)  Mr.  Mrs.  Ms.  Miss  Dr.  Prof.  Rev.

First Name \_\_\_\_\_ Nick Name \_\_\_\_\_

Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_

Address 1 \_\_\_\_\_

Address 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Phone \_\_\_\_\_ Secondary Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Home Email \_\_\_\_\_

Work Email \_\_\_\_\_

*By providing my email address, I authorize my doctor to contact me via the email address(es) provided.*

Which email address would you like us to use to communicate with you? (check one)  Home  Work

Contact Method (check one)

Primary Phone  Secondary Phone  Mobile Phone  Home Email  Work Email

Date of Birth  /  Age \_\_\_\_\_ Gender (check one)  Male  Female  Unspecified

Marital Status (check one)  Single  Married  Other

Employment Status (check one)

Employed  FT Student  PT Student  Other  Retired  Self Employed

Race (check one)

White  Black/African American  Hispanic  American Indian/Alaskan Native  
 Asian  Asian Indian  Chinese  Filipino  
 Japanese  Korean  Vietnamese  Native Hawaiian or other Pacific Island  
 Samoan  Guamanian or Chamorro  Other \_\_\_\_\_  I choose not to specify

Multi-Racial (check one)  Yes  No  Unknown

Ethnicity (check one)  Hispanic or Latino  Not Hispanic or Latino  I choose not to specify

Preferred Language (check one)

English  Spanish  American Sign Language  Chinese  French  German  
 Tagalog  Vietnamese  Italian  Korean  Russian  Polish  
 Arabic  Portuguese  Japanese  French Creole  Greek  Hindi  
 Persian  Urdu  Gujarati  Armenian  I choose not to specify